

UnitedHealthcare Community Plan of Tennessee Medical Policy Update Bulletin: February 2024

Access a policy listed below for complete details on the latest updates. A comprehensive summary of changes is provided at the bottom of every policy document for your reference. To view a detailed version of this bulletin, click [here](#).

Medical Policy Updates

Policy Title	Status	Effective Date
Airway Clearance Devices (for Tennessee Only)	Revised	Apr. 1, 2024
Deep Brain and Cortical Stimulation (for Tennessee Only)	Revised	Apr. 1, 2024
Elective Inpatient Services (for Tennessee Only)	Revised	Mar. 1, 2024
Electroretinography (for Tennessee Only)	Revised	Apr. 1, 2024
Genetic Testing for Hereditary Cancer (for Tennessee Only)	Revised	Apr. 1, 2024
Implanted Electrical Stimulator for Spinal Cord (for Tennessee Only)	Updated	Mar. 1, 2024
Injectables for Reconstructive Procedures (for Tennessee Only)	Revised	Apr. 1, 2024
Intensity-Modulated Radiation Therapy (for Tennessee Only)	Revised	Apr. 1, 2024
Interspinous Fusion and Decompression Devices (for Tennessee Only)	Revised	Apr. 1, 2024
Light and Laser Therapy (for Tennessee Only)	Revised	Apr. 1, 2024
Liposuction for Lipedema (for Tennessee Only)	Revised	Apr. 1, 2024
Omnibus Codes (for Tennessee Only)	Revised	Apr. 1, 2024
Percutaneous Patent Foramen Ovale (PFO) Closure (for Tennessee Only)	Revised	Mar. 1, 2024
Proton Beam Radiation Therapy (for Tennessee Only)	Revised	Apr. 1, 2024
Sacral Nerve Stimulation for Urinary and Fecal Indications (for Tennessee Only)	Revised	Apr. 1, 2024
Thermography (for Tennessee Only)	Retired	Feb. 1, 2024
Transcranial Magnetic Stimulation (for Tennessee Only)	Updated	Mar. 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Botulinum Toxins A and B	Updated	Mar. 1, 2024
Complement Inhibitors (Soliris® & Ultomiris®)	Revised	Mar. 1, 2024
Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®)	Revised	Mar. 1, 2024
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	Revised	Mar. 1, 2024
Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®)	Revised	Mar. 1, 2024
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Mar. 1, 2024
Stelara® (Ustekinumab)	Revised	Mar. 1, 2024

General Information

The inclusion of a health service (e.g., test, drug, device, or procedure) in this bulletin indicates only that UnitedHealthcare is adopting a new policy and/or updated, revised, replaced, or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the health service. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a health service must be determined in accordance with the member's benefit plan and any applicable federal or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Medical Policy Update Bulletin was developed to share important information regarding UnitedHealthcare Community Plan of Tennessee Medical Policy and Medical Benefit Drug Policy updates. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

Policy Update Classifications

New

New clinical coverage criteria have been adopted for a health service (e.g., test, drug, device, or procedure)

Updated

An existing policy has been reviewed and changes have not been made to the clinical coverage criteria; however, items such as the clinical evidence, FDA information, and/or list(s) of applicable codes may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the clinical coverage criteria

Replaced

An existing policy has been replaced with a new or different policy

Retired

The health service(s) addressed in the policy are no longer being managed or are considered to be proven/medically necessary and are therefore not excluded as unproven/not medically necessary services, unless coverage guidelines or criteria are otherwise documented in another policy



The complete library of Medical Policies and Medical Benefit Drug Policies for UnitedHealthcare Community Plan of Tennessee is available at UHCprovider.com/TN > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > [UnitedHealthcare Community Plan of Tennessee Medical & Drug Policies](#).